

Warwick
Medical School

Family Action Perinatal Support Project

Research Findings Report



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Executive Summary

Background

The prevalence of perinatal mental health problems is high with estimates suggesting that around a fifth of women experience *ante-natal* anxiety and or depression, and even higher numbers of women experience postnatal anxiety/depression. The consequences of such mental health problems in pregnancy include an adverse impact on the development of the foetal and infant nervous system, and the parent-infant relationship during the postnatal period, with significant long-term consequences. Current need exceeds statutory sector capacity, and the voluntary sector has been identified as having a key role to play in supporting women with anxiety and depression during the perinatal period.

Family Action Perinatal Support Project (PSP)

The Family Action Perinatal Support Project was established at four sites across the UK in 2010 and evolved from the early work of Newpin. The aim of this service was to offer women experiencing *perinatal* anxiety and depression support from volunteer befrienders who had experienced such perinatal mental health problems.

A total of 86 volunteer befrienders were recruited and trained, and the service was provided to around 189 women during the study period.

Methods

The evaluation comprised two components:

- a) A service evaluation addressing the impact of the PSP on key outcomes;
- b) Stakeholder interviews to explore perceptions about the PSP on the part of service providers and recipients, in addition to local referrers from a range of perinatal service networks.

Key Findings:

1. Service Evaluation

The quantitative data suggests that the PSP was serving a group of women with a high level of need; over two-thirds living in no-wage households, a third being single parent families and between 2 and 11% having child protection issues, in addition to the presenting problems (e.g. perinatal anxiety and/or depression). Around 20% of women did not take up the offer of the service, with some of these women being non-contactable.

Pre- and post-intervention data was collected from around one-third of the women who received the service. The results show significant improvements in anxiety and depression ($p < 0.00$), social support ($p < 0.01$) and self-esteem ($p < 0.00$). There was also a significant improvement in the mother's relationship with the baby in terms of warmth ($p < 0.00$), but not invasiveness ($p = .109$).

2. Stakeholder Interviews

Interviews (both face-to-face and telephone) were conducted with a total of 41 stakeholders including the following: co-ordinators ($n=5$); volunteer befrienders ($n=14$); recipients ($n=13$); and individuals from referring agencies ($n=9$).

The qualitative data confirms that the women accessing this service had complex needs including mental health problems, isolation, housing and financial problems.

Referrers to the service identified high levels of unmet need in their local populations and rated very highly the opportunity to refer women to the PSP. There was evidence of good partnership working between the voluntary and statutory sectors including effective information sharing and the conduct of joint assessments.

All stakeholders who were interviewed rated the PSP very highly and identified a range of benefits for both service recipients and volunteer providers.

A number of facilitators and barriers to effective working were identified. Facilitators included the location of PSP within existing Family Action sites; effective

management and support structures, and clear referral criteria. Barriers included the absence of standardised procedures and training; and problems with collecting and recording data.

Conclusion

Locating the PSP in established Family Action sites which are accessed by parents and multi-agency partners, and having access to effective line management appeared to improve the links with other services, the appropriateness of referrals, and the quality of the service provision.

The PSP was highly rated by all stakeholders, and appears to be filling a significant gap in service provision with women who have a high level of unmet need. There would appear to be further scope for the PSP to work with service users in the antenatal period where the impact may be even greater. This would involve shifting the emphasis in terms of referring agencies (e.g. encouraging more referrals during pregnancy from midwives). There would also appear to be scope for further standardisation across the sites and for changes to the methods of data collection.

1. Background

1.1 Policy

A broad evidence base has emerged over the past decade about the importance of supporting parents and parenting during the first five years of life. Current policy has focused on the early years (Field, 2010), and the joint Department for Education /Department of Health document 'Supporting families in the Foundation years' (2011) and the Allen Report (2011) point to the need to target resources and energies in this period. The Healthy Child Programme (DH 2009) supports the provision of a range of early evidence-based interventions aimed at supporting early parent-infant interaction, see for example, the Family Nurse Partnership programme (Olds 2006) and advocates an ante and post natal 'Promotional Interview' for parents with the health visitor (Purra et al 2005).

1.2. The Issue

1.2.1 *Mental Health Problems during the Perinatal Period*

Prevalence rates of depression in the *antenatal* period are similar to postpartum levels and range from 12% to 20% (Marcus et al 2003; Heron 2004). The prevalence of *postnatal* depression (PND) is in the region of 13%, ranging from 3 to 25% of women (O'Hara & Swain, 1996). There is also evidence of a high prevalence of postnatal depression in men, with estimates in the region of 10.4% (Paulson and Bazemore 2010), and a correlation between depression in fathers and mothers (ibid).

1.2.2 *Consequences of perinatal mental health problems*

Anxiety and depression in pregnancy are strongly associated with adverse outcomes for mothers and babies including preterm and low birth weight (Dunkel Schetter and Tanner 2012; Dunkel Schetter 2011). They are also associated with alterations to the neurobiological substrate of the affect regulation system of the foetus including for example, higher basal cortisol levels and reduced high-frequency heart-rate variability (HRV), low dopamine and serotonin levels (see Bergner, Monk, Werner 2008). Longitudinal studies also show alterations in HPA axis (hypothalamic-pituitary-adrenal) functioning in 10-year-old children (ibid).

Both anxiety (Beebe et al 2011) and depression (Murray 1996) in mothers during the postnatal period have been shown to have a deleterious effect on the parent-infant relationship, which in turn has been identified as being an important predictor of infant security of attachment (DeWolff and Ijzendoorn 1997), with insecure (e.g. Berlin, Cassidy and Appleyard 2008; Granot, Mayseless 2001; Sroufe 2005) and disorganised attachment (Green and Goldwyn, 2002) being associated with a range of compromised outcomes. Depression in fathers during the postnatal period is also associated with adverse emotional and behavioural outcomes in children aged 3-5 years (Ramchandani et al 2008).

1.2.3 Detection and management of perinatal anxiety and depression

Detection and management of perinatal anxiety and depression is complex and requires sensitivity on behalf of professionals and helpers. The associated stigma attached to having a mental health problem means that many women do not seek or receive the support they need, and *Suffering in Silence* (2011) advocates a multifaceted approach which includes raising awareness of the issue through national campaigns, and endorses an antenatal role for health visitors in order to strengthen assessment and identification of anxiety and depression.

Supporting the mother (and father where possible) and the developing infant through this period is recognised to be a key time for intervention in order to mitigate the above negative outcomes. A number of psychological therapies have been found to improve maternal mood (Cooper and Murray, 1998), and NICE (2006) guidance on effective treatments for PND includes talking therapies and counselling with an emphasis on timeliness in relation to both identification and treatment. However, research suggests that only interventions that focus on the infant in addition to parental depression, improves outcomes in terms of parent-infant interaction (Cooper and Murray, 1998).

Evidence suggests that current need in terms of women experiencing perinatal anxiety and depression exceeds statutory sector capacity (*Suffering in Silence*, 2011), and that many women are being prescribed drugs for such problems, particularly during the postnatal period (*ibid*).

1.3 The Role of the Voluntary Sector

Voluntary sector services, such as Family Action are traditionally independent of the statutory sector, reflected in their way of working and their vision (Spratt *et al.*, 2007). Usually small and flexible, they are characterised as being user-focused, cost-effective and as working with minimal bureaucracy and hierarchy (Spratt *et al.*, 2007; Lester *et al.*, 2008). These advantages have been recognised by the state and have been exploited in order to connect with hard-to-reach communities (Spratt *et al.*, 2007). The voluntary sector is as such fulfilling an important role not only by supplementing statutory provision (Dyson and While, 2002) and filling gaps (Andrews *et al.*, 2003), but also by innovating new solutions and mediating new relationships between state and citizens (Spratt *et al.*, 2007).

1.4 Family Action

1.4.1 Introduction

Family Action is a charity and leading voluntary sector provider of services to disadvantaged and socially isolated families, working with an emphasis on family support and early intervention. In 2005 Family Action merged with Newpin whose work, underpinned by Attachment Theory and emphasising peer support, has been the basis for the development of the PSP. A randomised controlled trial of the Newpin service found that women assessed as vulnerable to perinatal depression who received social support were half as likely as those in the control group to have experienced the onset of a depression sufficiently severe enough to warrant antidepressants, or to have remained without recovery from depression throughout the 12-month study period (Harris 2008). A subsequent evaluation of a pilot project - the Family Action Newpin Southwark Perinatal Project - demonstrated improved outcomes for participants (Lederer 2009).

The Perinatal Support Project emerged from the above projects, and was established in July 2010 and is due to complete in July 2013. The project was funded by the Big Lottery, The Monument Fund and the Henry Smith Charity.

1.4.2 The Perinatal Support Project (PSP)

The term 'Perinatal' is defined as '*Pertaining to the period immediately before and after birth*' (i.e. generally starting at around the 20th to 28th week of gestation and ending around four weeks after birth). The Perinatal Support Project (PSP) offers a service for mothers during the perinatal period and continuing as needed up to the infant's first birthday.

The PSP comprises a service for mothers who are either affected by, or at risk of postnatal depression and other mental health problems. The service has been established in four areas of the UK, only one of which (Oxford) does not have existing Family Action services. The four areas are diverse and contrast strongly particularly in terms of ethnicity and geography:

Hackney: Is the most deprived of London's boroughs, demonstrating poor outcomes across a range of dimensions. Situated in a multicultural area, the PSP is based alongside established Family Action services, delivering a variety of services with a focus on mental health and wellbeing such as counselling, housing services and a black and ethnic minority group service catering for the Somali, Congolese and Vietnamese population;

Mansfield: is a largely urban area of North West Nottinghamshire and is ranked amongst the 10% most deprived areas of England. The PSP is situated in the well established Family Action run Pleasley Hill Children's Centre and exhibits strong, established multi agency relationships;

Oxford: The Leys area of Oxford is one of the 20% most deprived areas of England. The PSP occupies a room in a community centre, situated in the middle of a housing estate. There are no established Family Action services in the locality;

Swaffam: Norfolk has a mix of urban and rural areas, outside the major urban areas of the county there are often significant pockets of deprivation of which the town of Swaffham is an example. The PSP is based in a community hospital and shares an office with other established Family Action health and wellbeing services. Geography plays a big role in operationalizing the PSP in this area.

1.4.3 Aims of PSP

The aims of PSP are fourfold:

- Improve the mental health of participants
- Improve attachment between mothers and infants
- Reduce social isolation
- Improve self-confidence of both participants and volunteers

1.4.4 Eligibility Criteria

Women who are vulnerable, or with mild to moderate mental health issues and are pregnant or mothers with infants under one are recruited to the project via a range of referral routes including Midwives, General Practitioners or Health Visitors. Women may also self-refer. Women with severe mental illness are not offered the service.

1.4.5 Provision

The PSP provides intensive community-based support throughout the women's pregnancy and during the first year of the child's life. Support ceases on the infant's first birthday.

The PSP involves:

- Assessment of need by a project co-ordinator;
- Recruitment, training and supervision of volunteer befrienders;
- Maintenance of referral networks by the project co-ordinator;
- Provision of home visits by a suitably qualified and trained volunteer befriender;
- Provision of parenting groups to increase understanding and knowledge of the infant's needs;
- Provision of help to develop informal support networks.

2. Methods

2.1 Study design

The evaluation comprised two components:

- A) Service evaluation addressing the impact of the PSP on key outcomes;
- B) Stakeholder interviews to explore perceptions about the PSP within service providers and recipients, in addition to local perinatal service networks;
- C) Workshop: to explore the Theory of Change for the PSP (See Appendix (ii)).

2.2 Service Evaluation

2.2.1 Study Population:

All families who took part in the Family Action Perinatal Support Service were required by the project coordinator to complete a range of standardised measures (see 2.2.2 below) on entry to the project (i.e. at baseline), and following completion of service delivery (i.e. post-intervention).

2.2.2 Data collection instruments:

To measure outcomes for service recipients (and volunteers in the case of the RSE):

- Mental health and wellbeing: Hospital Anxiety Depression Scale (HADS).
- Mother-child relationship: Mother Object Relationship scale (MORS).
- Social isolation: Maternal Social Support Index (MSSI).
- Rosenberg's Self-Esteem Scale (RSE)

2.3 Data management

Quantitative data were collected and entered into a database by Family Action, and then sent to the University of Warwick for analysis.

2.4 Data analysis

A range of descriptive statistics (means and chi-squared tests) was used to depict the demographic characteristics of participants, and t-tests were used to assess whether there is statistically significant change between the baseline and post-intervention measures of outcome;

2.2 Stakeholder Views and Experiences

2.2.1 Recruitment

All Project Coordinators were invited to take part the research and were instrumental to identifying other participants. Project Coordinators identified and approached volunteer befrienders (VB), details of VB interested in participating were given to the researcher who explained the study in detail, and obtained full informed consent prior to interview.

Service users were identified and recruited by the Project Coordinator who explained the research in detail and obtained full informed and written consent prior to details being passed to the researcher. Any further questions were discussed in detail prior to conducting an interview at a time convenient to the participant.

2.2.2 Semi-structured interviews

Semi-structured interviews were conducted with all consenting stakeholders at a time and location convenient to the stakeholder, and all interviews were recorded. Telephone interviews were conducted with the majority of service users.

2.2.3 Data management

All interviews were fully transcribed, returned to the interviewee for comment, and then entered into the qualitative database, NVivo 8.

2.2.4 Data analysis

A thematic analysis was undertaken in order to identify the main themes emerging from the data.

2.3 Research governance

The research was conducted in accordance with the University of Warwick Research governance procedures. This provides guidelines concerning the safety of study participants and researchers, data confidentiality and regulations with regard to the storage and eventual destruction of data.

Ethics committee approval was provided by the University of Warwick Research Ethics Committee.

3. Service Evaluation

3.1 Introduction

Data are calculated from the start of the project (variable start dates from July 2010 to end May 2012). Percentages have been rounded to whole figures.

3.2 Referrals and Service uptake

Referrers to the PSP varied across the four sites with Swaffam and West Mansfield receiving the majority of referrals from **Health visitors and Midwives**, while in Oxford the **Perinatal Mental Health service/community midwives** made up the majority of referrals, and in Hackney the majority were made by a **Voluntary organisation**.

Table 1 shows the number of referrals to each site, the on-going cases, the cases closed and numbers of trained volunteer befrienders at each site. The main reasons for referral to the PSP were predominantly ‘mental health of parent’ or ‘attachment problems’.

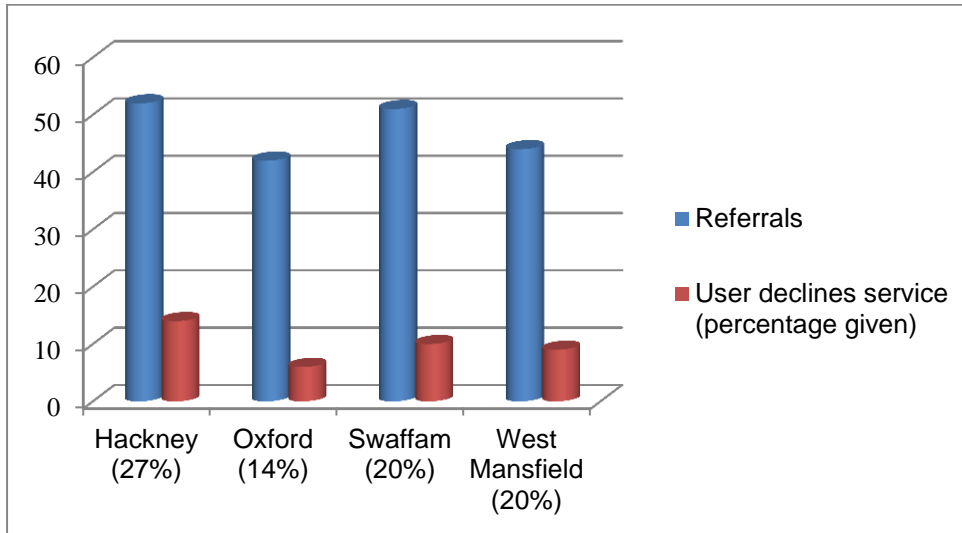
Table 1: Numbers of referrals to the PSP

Service Name	Total Referrals	Cases On-going	Cases Closed	VB
Hackney	52	26	26	29
Oxford	42	11	31	12
Swaffham	51	12	39	30
West Mansfield	44	17	27	15
<i>Totals</i>	<i>189</i>	<i>66</i>	<i>123</i>	<i>86</i>

Table 2 shows the uptake rate to the four sites, which was in the region of 80% (range 73% to 86%). There is little evidence to indicate why some women who were referred to the PSP did not take up the offer of the service, and Project Coordinators were not able to identify any consistent features (i.e. they were introduced via the

usual referrers). No data was collected regarding the demographic characteristics of the families who did not take up the service.

Table 2: Uptake rate



3.3 Sociodemographic characteristics of service users

Table 3 shows that around a third of this sample were lone parents, a further 11% comprised reconstituted families, and 42% were birth parents.

Table 3: Family composition

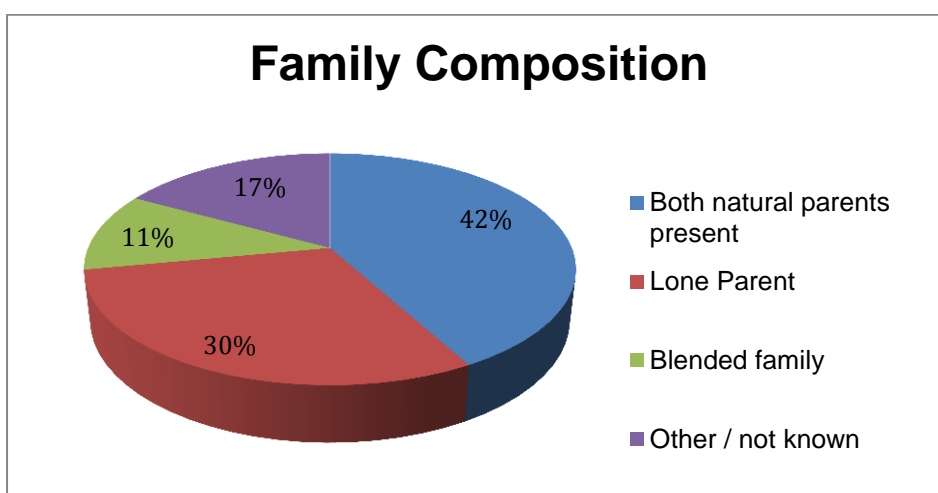


Table 4 shows that the PSP was serving a very disadvantaged group of families with between 57% and 73% living in households with no waged income.

Table 4: Referrals to the PSP - No waged adults in family

Service Name	Unwaged adults	Percentage
Hackney	38	73%
Oxford	25	60%
Swaffham	29	57%
West Mansfield	29	66%

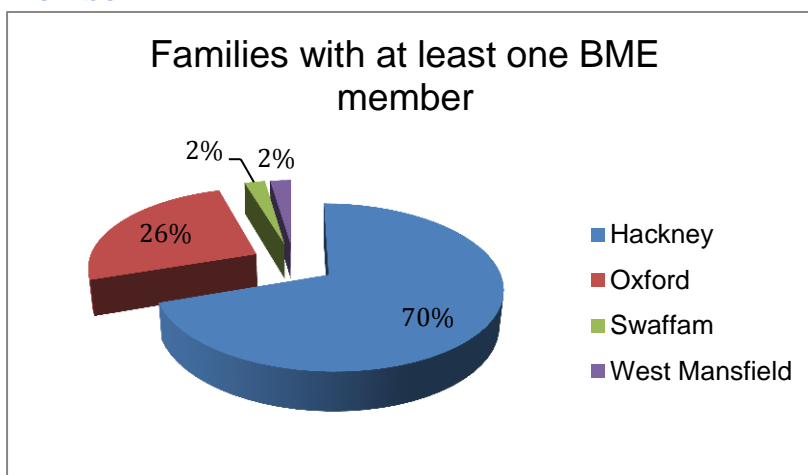
Table five shows the numbers of families within each area on the Child Protection Register or with a child protection plan in place.

Table 5: Families with one child on the Child Protection Register

Service Name	Number	%
Hackney	6	11.5%
Oxford	1	2%
Swaffham	3	6%
West Mansfield	1	2%

Table 6 shows that Hackney had the highest proportion of ethnic minority families.

Table 6: Ethnicity: Families with at least one black or minority ethnic group member



Three families had a learning disability and Table 7 shows the small number of service users with a physical disability.

Table 7: Adult Physical Disabilities

Service Name	Number	%
Hackney	6	11.5%
Oxford	3	7%
West Mansfield	1	2%

3. 4 Service Evaluation Results

Table 8 shows the mean (standard deviation) scores pre- and post-intervention for the four key outcomes. The results show significant improvements in anxiety and depression ($p < 0.00$), social support ($p < .01$) and self-esteem ($p < 0.00$). There was also a significant improvement in the mother’s relationship with the baby in terms of warmth ($p < 0.00$), but not invasiveness ($p = .109$).

Table 8: Mean scores for the key measures pre and post intervention
(Standard deviation in brackets)

Measures	N	Baseline	Post- Intervention	Sig
Parental mental health				
<i>Anxiety</i>	33	11.8 (4.1)	8.4 (3.8)	.000
<i>Depression</i>		10.1 (4.3)	6.1 (2.7)	.000
Mothers relationship with the baby				
<i>Warmth</i>	35	22.9 (7.8)	29.0 (4.4)	.000
<i>Invasiveness</i>		12.1 (6.3)	10.3 (5.3)	.109
Social Support	42	18.7 (6.3)	20.6 (5.2)	.007
Self-Esteem (Volunteer Befrienders)	80	30.6 (4.8)	32.2 (4.4)	.000

3.5 Summary

Overall, the results of this service evaluation suggest the following:

1. The PSP is serving a population with significant levels of unmet need;
2. There is an improvement in outcomes across the board for those families for whom pre and post intervention data were available (26 – 33% of families).

The PSP received a significant number of referrals over the study period ranging from 53 to 78. Reasons for these differences in referral rates include the variation in the site starting date. Numbers of trained volunteers ranged from 15 – 30 at each of the four sites, suggesting that over the study period (i.e. 18 months) each volunteer worked with approximately 2 – 3 families in total during the study period.

The data suggest that the PSP served a group of women with a high level of need: over two thirds living in no-wage households, one-third being lone parents, and between two and eleven percent having children on the child protection register or with a child protection plan, in addition to the presenting problems.

The characteristics of families who do not take-up the offer of the intervention (around 20%) are not known, however, and it was not possible to obtain both pre and post outcome assessments for around two-thirds of the families receiving the intervention

4. Stakeholder views and experiences

4.1 Study population

Interviews were conducted with a range of stakeholders including service providers and recipients, in addition to individuals from referring agencies. Face-to-face and telephone interviews were conducted with a total of 41 individuals.

Table 1: Research participants

National Coordinator (1)	✓			
Category	Hackney	Mansfield	Swaffam	Oxford
Project Coordinator (4)	✓	✓	✓	✓
Volunteer Befriender (14)	✓	✓	✓	✓
	✓	✓	✓	✓
	0	✓	✓	0
Service Users (13)	✓	✓	✓	✓
	0	✓	✓	✓
	0	✓	✓	✓
	0	✓	✓	✓
Referrer (9)	✓	✓	✓	✓
	✓	✓	✓	✓
		✓		
Total: 41	1	7	12	11
				10

4.1.1 Volunteer Befrienders

Volunteers who were interviewed had the following characteristics;

- Age range: 20 – 60's with over half in their 40's
- All but one had children
- Half of the sample claimed to have suffered from PND
- The majority described themselves as 'White British'
- One was single with no children
- Most were either married or in stable relationships

Mindful of the population with whom VB would be working (e.g. Hackney where specific language skills or understanding of cultural issues were of value), Project Coordinators selected VB appropriately.

4.1.2 Service users

Service users who were interviewed were aged between 20 and 45, the majority in their twenties; they were all in relationships and cohabiting except one mother who had separated from her partner. Apart from one African woman, all classed themselves as 'White British'. Numbers of children ranged from 1 – 5. One Father took part in the research.

4.2 Experiences of the project

4.2.1 Referrers

Agencies referring to the project were unanimous in their appreciation of the PSP, and the potential support available to clients who had previously been unable to access suitable services. One health visitor referred to the level of need in her area as follows:

Yeah very high need. Um. I'd say um probably twenty five percent of my adults that I continue to visit is because of emotional health problems, including postnatal illness. So there's a very high need in this area.(Referrer #10)

So it's um quite a large council estate. Sort of a variety of accommodation and properties. Um. And quite a varying background of social backgrounds and family situations. So sort of varying. Probably not from the more affluent parts. But it's mainly working class families because it is an ex mining region. Um. But we've also got quite a large immigrant population as well. Consists

of a lot of Eastern Europeans and Asian families. So quite a diverse area. Quite a lot of unemployment. Um. A lot of social needs. And also there's quite a lot of domestic violence as well. So quite a high need. (Referrer#10)

A family support worker described attempts that had been made by other services to address the high level of need in terms of perinatal depression in particular:

We worked with a lady from CAMHS um quite a number of years ago. Because we identified... a lot of the referrals that we were getting were around postnatal depression. And at the time we had no experience um in it at all and was really not knowing what kind of support we could give them and what direction you know the parents needed. So X came from CAMHS and she did a bit of work with us where any referrals coming in or any ones that we thought was um a parent with postnatal depression, we were referring to her. She'd go out um, do a check sheet with them and then devise a package of support for that parent really. But that was only funded I think it was for a year, may have been nine months or a year. So a very short period of time. However, the volume of referrals that we were referring to her was just massive really. (Family Support Worker # 7)

Referrers were unanimous in agreeing that the PSP filled a gap left by other services. Front line practitioners such as midwives, health visitors, family workers and social workers, embraced the project wholeheartedly and were delighted to have a service such as the PSP to refer on to:

But I thought mm that sounds really good because we deal with um lots of mums who are socially isolated or culturally isolated, who have difficulties getting out, who suffer with a bit of depression, but not serious enough to bring in the services of sort of mental health or anything. (Social worker# 20)

My initial reaction was this will be brilliant if it's going to actually give us somewhere to refer the ladies that aren't seen by the psychiatric team and the community psychiatric nurses. We obviously as midwives we're very very busy and the amount of visits we do are getting less and less. So for women to get support if they've got mental illness or you know borderline mental health problems, especially women that we've had that have had premature babies or there's lots of other little things underlying that you know they could do with some support, but up until now we've had nowhere that we could actually send them. So from our point of view it's lovely to know that we've got some support out there for our new mums or even antenatally if they've got problems to actually go and get some support. (Midwife # 8)

Referrers had mostly learned about the PSP as a result of the project co-ordinators dissemination activities to midwifery, health visitor or multidisciplinary team meetings. Other sources were also identified:

I'd never heard of it until I actually saw an advert in the local [paper]and it... a nice little advert which... not an advert, it was a little article that I think had a photograph of [coordinator] and stating how she became involved in doing this and a referral telephone number. (Referrer #20)

Referrers to the PSP appeared to have a broad understanding about what the project offered:

I would say that it's a befriending service. Home visiting, which I think is very important at the beginning. Um. It also supports mothers to deal with some of the practicalities of having children, like filling in forms and getting to places and making phone calls. And you know for example doing things when the children are at school or um getting out and meeting other people especially. That's something that I usually ask them to look at. (Social Worker # 20)

There was also evidence of partnership working across the statutory and voluntary sectors:

Very much so. Yeah we've got a good relationship with all the staff over here, x {Coodinator] included. So we do. I mean we share information. If we've got concerns about families we'll talk to each other. Um. Yeah. We have got a very... I've worked with other Childrens Centres... not with the perinatal service, but with other Surestart [Childrens] centres and I think we've got a very good relationship with the staff here and with X [Coodinator]. (Referrer#10)

The use of joint assessments was highlighted, and the feedback provided by PSP co-ordinators was highly rated:

Very good feedback I have to say. Um. So written updates. Um. Letters. Emails. Verbal updates. Um. We do joint visits. Joint assessments. Initial visits.(Referrer #23)

In one area where a majority of referrals were from the Perinatal Mental Health service seeking to refer clients who are exiting their service but require on-going support, the process of accepting a referral was often 'negotiated' through phone calls and discussion:

We can always have a case discussion with the psychiatric service. So if they think it's appropriate. And the same with Coordinator as well. *So you just pick up the phone to Coordinator would you?* Yes. I speak to her quite frequently. (Referrer #10)

4.2.2 Volunteer Befrienders

4.2.2.1 Benefits for families

Volunteer befrienders described a range of ways in which they felt the support that they provided had benefited the families:

Extremely valuable. And I think without it being here it would... well it would be an awful thought to think what's happening with these women. (VB#4)

But I remember this particular girl the first time I met her she just... I could tell by her eyes what pain she was in. She just had... she sort of glared at me. And now she does actually look happy again and there is that sparkle in her eyes. (VB#11)

[...]For me it was just because I'd been there and I knew it and you know and I just thought it was such a good idea to be able to go and help somebody who felt you know really awful or whatever. And I think the way it's been done, the whole thing and everybody there is so nice and supportive, and I think that's what helps it work. Because [Coordinator's] so lovely and everybody I've met and all the training bits and that. Everybody just wants to help. And they're all really focussed on what they're doing. So you know I think it just... you know it's just been a really really good experience. (VB#30)

One volunteer described the way in which she felt the visits increased women's self-esteem, and empowered them:

Just giving that person that little bit of like self-esteem. Oh that actually she can do this. And if I do this then I can do that. I think it's about empowering people. Because a lot of people... I don't know.. sometimes when you're like... you might be in a dark place and stuck in a bit of a rut, you might think there's nothing going to happen and nothing can get better. And if someone cares about you I think it's quite a nice feeling.(VB#32)

A number of volunteers referred to the improved relationship between the mother and the baby:

The best thing is just seeing the moments that are happening all the time, but just being privileged enough to sit there and see a baby respond in a certain way to their mum. And you say wow. And it always brings... it makes me quite emotional seeing it you know. You think wow he's just done that, look at how wonderful that is. And then the mum is saying yeah you know he hasn't done that before and you know that that moment, she's going to remember that moment. And that's connecting to them you know. So that's always a privilege really seeing moments like that. I feel quite lucky to see those. (VB#13)

4.2.2.2 Benefits for the volunteer befrienders

Many of the volunteer befrienders had personal experience of perinatal anxiety/depression and some referred to the lack of appropriate services that had been available to themselves at the time:

I think it's just kind of helping people who've had my own experiences. Because I'm a mum, so I'd had children... I've had postnatal depression. So I've dealt with it from that side. (VB #31)

Volunteer befrienders also described a range of ways in which they felt that the role of befriender as part of PSP had benefitted themselves and their families. One volunteer referred to an increased sense of acceptance:

It's just really... I just found it really rewarding. I wanted to give something back to the community really and I feel that I have done that. Um. It's kind of made me feel accepted in a way. (VB#11)

Other interviewees identified an increase in their own sense of empowerment, and ability to manage their own feelings:

So while actually I was trying to empower woman, I was empowered indirectly and that's very important I think. (VB#19)

Yeah I think it has. I think a great deal's changed for me.

[What sort of things might have changed?]

I just feel different in myself. I feel more able to cope with my own feelings as well as trying to help someone else cope with theirs. I understand a lot more about the way people feel. (VB#28)

Some volunteers described feelings of increased confidence, and one felt that it had improved their job prospects when they returned to work:

Probably... I know I'd like to do something workwise pretty similar to what I'm doing now. Um. And I've done a lot of training and because I'm now doing Homestart as well... I've done loads of different things. And you know I think my job prospects in the future when I can go back to work you know are probably quite a lot better. And I've probably got a lot more confidence going into work now and stuff like that than I had before. (VB#30)

One volunteer described this as being her motivation to undertake the training:

It was when I was actually at college doing my access course. We had an email through from our lecturer about the perinatal project. And it just said that you could go and train and then do some voluntary work. And so I sort of sent off and [Coordinator] sent me all the leaflets about it and I thought well it sounded really interesting and a good cause it was also relevant to my midwifery and would be good for my CV (VB #36)

Some volunteers also felt that the project had impacted on their relationship with their family:

Um. Like with my daughter in law I'd be... I'd be saying Oh do it this way or that's not a big deal... but now I tend to sit and listen to her more and I think understand her better. (VB #35)

And I'm really pleased that I have sort of gone through with it really because it's helped me and also it helps my daughter to think that you know my mum's out there and... My daughter's counsellor said to me it's no good you staying in all the time with your daughter... which is what you want to do if they're depressed and stuff... she said because you'll get depressed. She said you've got to lead your life and show your daughter that going out is normal you know. So my daughter's proud of me and she's getting better as well. So that's good. (VB #33)

The volunteers recognised both the need and the distinctive way in which the PSP supports women, offering a service which has the needs of the participating women at its heart:

Um. I think the thing about it is that its mums you know. We are mums and we you know... it's sort of like power to the mums. We've been there. We can... we can't ever imagine how an experience is for somebody and what that's done to them, but we can empathise with them and perhaps give a bit of support and say look it can get better and it will get better and there's hope and there's people that can help and there's things that you can do and just keeping it all open and helpful. (VB#13)

One volunteer referred to the on-going unmet need:

....It seems as if you know the project is really good, the intentions are brilliant, it's just that the level of need is so great once you start uncovering it. You know. You begin to realise that Oh crikey we're actually only touching the surface of this. (VB#26)

4.2.3 Service recipients

The quantitative data highlighted the high level of need in the population being served by the PSP, and this was confirmed by the interviews with the service recipients, which indicted a range of problems:

I had quite a rough pregnancy, not with so much health, but a lot of bad things happening with my ex-partner. (SU#9)

And so I'm... when I first came up here I was just put into work, so I didn't have many... well I didn't have no friends and um I'm quite shy and then when I had my daughter who's actually two now, um I didn't mind so much um... but now I've got my son and I had a difficult time in pregnancy and birth and um I

just felt so isolated and um I just went to one of the Surestart groups and um I just broke down and you know everything came out. Some about my past and that. And um you know I hadn't got no friends. (SU#41)

Many women referred to feelings of isolation, emptiness and being terrified about their situation:

A bit empty. A bit terrified. I didn't like my new child and it was very unnatural to me. Because my first one was just like it was really really natural, there was no problems of anything.

So before I started my work um I was very very lonely and very isolated and having the volunteer come up once a week I knew that even if I didn't see anybody else that week I would be seeing her. And it was kind of like a little bit of normality. Yeah that's the word. (SU#14)

One lone mother of a toddler and pregnant with twins described the impact of her antenatal depression on her young daughter:

Because she used to like to sit in one corner and stay there. Because sometimes I thought one day she was even sick but she wasn't. But I think it was the situation and the place where we were staying it was small. And myself I was depressed so I didn't have time for her. Like I was thinking Oh what is going to happen tomorrow. (SU#12)

The PSP supported this mother through this difficult time, 'containing' her while she made practical changes such as applying for a housing move and also supporting her to focus on her child and the impending birth of the twins.

A number of women highlighted the importance of being given the opportunity to socialise with other mothers and babies:

So we've been to a baby centre like she has suggested. We... to get her socialised with other babies once a week. I know we're her family, but there's still other children and babies. So we do do that. So she has helped us with the sort of socialising. Because obviously I was frightened to take her to baby centres and stuff. Especially on my own. (SU#17)

Some interviewees highlighted the need for additional support beyond that of their immediate family:

To have somewhere to go once a week and meet other people and sort of somewhere if you like to offload a few of your problems and somebody just to get you to understand that it's not you that's a bad person that... do you know what I mean. Oh I can't explain it. It's support. Because you've got your partner, you've got your immediate family, but..my mum's fantastic and we're really close, I don't know....So I think without having [Project coordinator] and

the other girls there to understand it's not just me and there's somebody else there, I don't know where I'd be now to be fair. (SU#9)

The following provides examples of the sort of support the VB were providing:

And she was... I mean I don't know the technical terms, but she was quite withdrawn and she wouldn't talk to you sort of eye to eye. You know. And generally I don't think she trusted people either from her past. So she wasn't... I was a little bit... because I'm quite chatty and sort of open and I thought Oh am I going to be too sort of chatty for her really. But um as the time went on um we've become really good friends and you know she'll talk to me about all sorts of things and look me in the face. So I feel that you know I've helped her quite a bit... (VB#33)

I have um supported mums in the way that they want to be supported. It's quite hard sometimes to sort of find what they need because they don't often know what they need. So I've gone in and I've offered baby massage. That's one of the special things that I do I suppose. A unique thing that I do with the mums and I've offered that to both of the mums that I've seen. Um. I've supported them to get out and about and sort of made them aware of what... like the things that are happening in the town at the children's centre and what's available for them to go and use. (VB #13)

She's depressed. She's certainly struggling with it. I mean she lives on the 12th floor of a tower block. It's two bedrooms. Two bedrooms and four children. You know. And we've helped her get... you know she wasn't in the right band to move to different housing. And so I helped her fill in a form to send off to the Council so they knew how many children she had and which would get her in the correct band and then she can then bid for a house. So she's quite excited about that (VB#18)

Although many women had initial reactions of anxiety (e.g. *A bit scary. Yeah [laugh]. A bit scary. A bit nerve wracking (SU#14)*), particularly about whether they would be able to talk to a stranger (e.g. *Being able to talk to someone that wasn't totally linked closely to you (SU#27)*) and some women expressed anxiety about admitting that they had problems and uncertainty about whether they would be judged negatively, the acceptance and non-judgemental approach of the volunteers soon relieved these anxieties:

It sounded good, yeah. Um. I was a bit sceptical about admitting that I might have needed some help because I thought people might judge me. But no X {Project Coordinator} made me feel at ease and everything so it was OK (SU#9)

I now know now not to be frightened to ask for help. So um we've also got a better family unit going um through the support of other people. (SU#27)

The overwhelming message from the interviews with the service recipients was one of relief and gratitude:

Just to thank [Coordinator] because she really really changed my life. I didn't know that one time I could be somewhere happy. That's the only thing I can say...Really really did a good job in my life. (SU#12)

A Case Study:

The following case study (names have been altered) illustrates the benefits of the PSP for one couple:

Tracy, Shaun and baby Tom

In answer to the question 'what difference this project had made to you' Tracy hesitated and in a voice filled with emotion said;

To be quite honest I think when we first had Tom he might have ended up in care.

Both Shaun and Tracy are in their late twenties, both have learning difficulties and Tracy is also physically disabled and a wheelchair user. Shaun is Tracy's full time carer. Both parents report unhappy childhoods and difficult relationships with their families and for Tracy, difficulties making and sustaining friendships.

The couple were stable and self-sufficient until their situation changed swiftly with an unplanned pregnancy and the birth of a pre-term infant at 28 weeks. Bringing home baby Tom was daunting, and both parents report feeling depressed and overwhelmed. For Shaun it represented an overload in terms of caring responsibilities;

I'll put my hand up. I said to Tracy I don't want him. I actually said that to her twice didn't I.

Tracy's depression stemmed in part from her knowledge about Shaun's feelings and her own feelings of feeling unprepared. The hospital care appeared to do little to prepare her for the practicalities of caring for Tom at home:

So we was in severe shock [laugh] stage. And then when he was born it was even worse because he wasn't supposed to be born until March. So then when he did come home Shaun's sort of like... because I'm... because of my disability I'm not allowed to pick Tom up or walk around with him

Because with Tom being premature, um we... I didn't really get a hands on with him in the hospital either. And they didn't know how to treat me because I was in a wheelchair at the time because of my C-section. So the thing... it was sort of like kid gloves for Tom and for me and they didn't quite know how to treat us.

The midwife working with the family referred them to the PSP soon after Tom was born, and while he was still in hospital. At this point there were a number of services involved in the family's care but it soon became apparent that the PSP was the key resource. Through the PSP both Shaun and Tracy were offered a volunteer befriender. This offer was immediately accepted by Tracy but declined by Shaun who felt that as long as Tracy was being helped, he could cope:

Because when Tracy's on a downer it affects me and it affects Tom. So of course when it's helping Tracy it helps me, it helps Tom

A number of other services were put in place via the PSP co-ordinator including baby massage and respite care for the parents when Tom was six months old. The latter was highly valued by both parents because it provided time for themselves but also an opportunity for Tom to mix with other infants, something they felt unable to provide for him, themselves. Tracy was also referred for counselling which she has found very helpful.

Shaun describes the project as follows:

Basically in one word supportive. That's how we found it. I mean they've been brilliant. I mean we come here... all the staff are brilliant. Can't fault one of them. I mean counsellor's helping Tracy. Coordinator... without her getting everyone together and everything... getting Tracy that befriender... I would say they've really helped. But in one word supportive I would say.

A planned withdrawal of support was in progress, as their independence and support from other services has increased.

5. Barriers and Facilitators

5.1 Facilitators

5.1.1 Utilising existing Family Action Structures

Hackney, Mansfield and Swaffam PSP were set up in areas in which Family Action were currently working and had an established base. These sites benefited from existing support structures including personnel and operating systems and processes:

And then you know I worked with the team here and used the systems that they've got in place for you know keeping people safe, in terms of case recording and all of that and just made it fit to the perinatal service, made some little tweaks. So again you know I didn't have to recreate anything or start from scratch with things there. *(Project Coordinator)*

Having an appropriate base was also valued by referrers to the service:

Yeah because the accommodation area, it's a nice centre. Um. So they've got an area where mums can come together and where there's a place for the children to go as well, crèche facility. And we know where she is so she's visible to people, she's visible to professionals and to families as well. So yeah I think it's ideal. (HV # 10)

As part of the implementation, Hackney, Mansfield and Swaffam also set up steering groups, inviting strategic people and services to be involved. This appears to have worked well for a variety of reasons such as creating a good point of contact, advertising the PSP and developing better understanding of referral criteria and processes:

We've got Homestart. The manager of our local Homestart. We have um a health visitor and the health visitor's changed, but we always have a health visitor representation. We have children's centre. Two children's centres in the area. My manager X and the infant mental health practitioner and me. So that was a good point because we had our first meeting very early on. I think I started in the August and we had one in the September. Um. So they gave me lots of ideas in terms of speaking to people. *(Project Coordinator)*

Preparation for steering group meetings also had additional unanticipated benefits in terms of enabling the Project Coordinator to pause and assess progress:

letting people know about what's going on. Um. But it's also been really beneficial for me in terms of helping me focus on you know what actually has happened over the last four months because it goes so quickly. *(Project Coordinator)*

5.1.2 Good site location

The choice of venue for the project base had an impact on how swiftly the project became active, and also its scope in terms of what could be delivered. Being based alongside other professionals appeared to enhance the Coordinators capacity to provide information, support and also referrals:

And where I fit into the whole remit is I get referrals from counselling, I'll get referrals from the GP practices, I get referrals from the BME team. So I get... I am quite fortunate is I've got a very good team that I can work off and I can also receive referrals from. *(Project Coordinator)*

It also meant that other established services were being utilised:

I also then did some work with the volunteer coordinator here [Children's Centre] and the counsellor that works across the X district to look at how we could use training that was already in the area, pool that together to meet the needs of this service rather than me running separate training. *(Project Coordinator)*

Being based with other professionals and having an effective line management structure meant that decisions were taken with confidence. Where this was not the case it appeared to take longer to decline inappropriate referrals, or to close the waiting list or to maintain basic 'safe and well procedures'.

5.1.3 Good management and support

The multifaceted role of the Project Coordinator with its array of constantly competing tasks mean that support for the co-coordinator is essential. Those who were receiving good line management and supervision really valued the process which left them feeling comfortable and supported, which in turn impacted on their functioning in their role:

So... and I think just the office that I'm based in, the centre that I'm based in, it just means that in terms of running, in terms of feeling safe and supported myself, um benefits for the service users and volunteers as well *((Project Coordinator)*

I've got a very good team you know, psychotherapists and clinicians. I'm able to tap into their thinking and offload my worries or concerns I have and get feedback and get strategies on how to best support the families *((Project Coordinator)*

Where these systems were absent, anxiety and frustration were apparent and inevitably appeared to impact on the role.

5.1.4 Good management and support

All VB spoke highly of their training which took on average one day a week for six weeks. Issues covered included confidentiality, child protection, family life and family stress, communication and listening skills, domestic violence, mental health postnatal depression and child protection.

It was really informative and I learnt lots about issues that I'd never even thought about very much. You know like domestic violence and things like that. Um. It just opened my eyes really to what was going on and the difficulties people were facing and how perhaps I could perhaps make a difference or help somebody (VB#13)

I really looked forward to going. It was really great to be out there with other people and all working towards the same thing. The training was really good. It was really informative and I learnt lots about issues that I'd never even thought about very much. You know like domestic violence and things like that. Um. It just opened my eyes really to what was going on and the difficulties people were facing and how perhaps I could perhaps make a difference or help somebody. Um. No it was really enjoyable. It was very enjoyable the training. (VB #13)

Some of aspects of the training were unanticipated but volunteers were unanimously positive about its content and the skills that it had helped them to develop. They also described feeling that it prepared them to start befriending:

Yes I felt a lot more able to do what we were intended to do. Because you don't realise before you do the course... you think Oh I'll just go and help, I'll be your friend, but there's a lot more to it than that. (VB#28)

I did, but I mean I was still nervous because you think well they might not like me or different things like that. Or you might not be any good at it and all that sort of thing. But yeah I think I felt as prepared as I could do. I mean I was still nervous (VB#30)

In addition to the basic training offered, a number of VB have been given opportunities for further training on a range of subjects such as Domestic Violence and these additional courses have been highly appreciated and valued by participants.

5.1.5 Establishing clear referral criteria

One of the first tasks was to identify some guidelines for referral:

Well for example um [Coordinator] would in the early days have been receiving quite a lot of referrals with quite a lot of heavy child protection issues that were live. Um. And we all agreed that our role wasn't to provide written reports or psychological um sort of assessments for GPs or anything of that nature. Nor was it wise at the early part to be heavily involved with child protection issues. Um. So that was one thing with regard to receipt of a referral. Plus if somebody's actively psychotic or heavily drug using or living with someone who's violent or experiencing um domestic violence, that that had to be thought about. So I think there was a pressure in the initial stages to accept referrals because they had to get the project up and running. So at one of our meetings it was decided that we kind of needed a criteria just to guide those referring in, but also to give a reference point for the Coordinators so that they can actually think you know is this a suitable referral at this stage.

In the early stages of the PSP there was a tendency to accept more borderline referrals in order to increase numbers. However, with experience more appropriate referrals were accepted. The appointment of a National Coordinator facilitated the development of a more comprehensive list set of criteria (See Appendix 1). This co-ordinator described her pro-active and flexible approach to referrals:

There's always a grey area. I think for me is if I know the mum's not coping and there's a risk to that child or a risk to her safety or sanity, I will go in and work with her. Um. It could be housing issues, finances, baby's got severe colic, mum's tearing her hair out, OK. Let's address these needs. I will do that. I can't be stringent, if I am I won't get any referrals. Um. I have to be flexible in what I do and that's... I can't say this is the only thing. Yes I won't do domestic violence when the perpetrator is in the home, but I will do domestic violence if they're in a Refuge. Um. So I have to be flexible.

The skills of the individual Project Coordinators may also have a bearing on the type of referrals accepted, and some referrals were accepted on the basis that the Project Coordinators would act as the befriender.

5.2 Barriers

5.2.1 Management Changes

The Hackney, Mansfield and Swaffam PSP's were established in August 2010 with the Oxford project following in October 2010. During this period, a number of changes had taken place within Family Action head office, with the PSP 'champion'

no longer in post. This appeared to have an impact on the ensuing role of the national coordinator whose appointment had been made on the understanding that her role would be one of support and marketing in regards to the PSP.

5.2.2 Absence of standardised practice

One of the difficulties identified by the project co-ordinators was the lack of standardisation across the sites, which caused frustration, a duplication of paperwork and a mismatch of working practice.

But I think if we perhaps were involved in or were even given a standard this is a minimum requirement you must all do this and then we could all go away and use what was local to add to that or tweak it. I think that would have been the ideal (*Project Coordinator*)

5.2.3 Utilisation of existing structures

The project established in Oxford was not part of an existing Family Action site, and the location of the project was driven by the Project Coordinator:

It was entirely down to me. Yeah I was just told to find an office and this is what I found.

The project co-ordinator described many difficulties that she experienced, some associated with the isolated project base, a lack of infrastructure, difficulties with IT and limited support

5.2.4 Data collection and Monitoring

Much of the unease on the part of the Coordinators around monitoring and evaluation concerned the format of the questionnaires. The data collection instruments currently in use are not user-friendly, and in some cases the scoring has not been removed from the questionnaire, which may bias the response.

The end of project review includes a one-to-one visit and project end data is usually completed at this time. Strategies have developed throughout the duration of the project to aid data completion and this includes Coordinator assisted completion of the questionnaires at this time in three of the four areas.

All Coordinators have experienced difficulties with obtaining end of project data, as participants disengage from the project as their mental health and wellbeing improves. However the Coordinators feel that the whole process of engaging and sustaining participants has improved over time (including more appropriate referrals) and that these issues are less pertinent currently than at the start of the project.

Coordinators plan their time on the database by scheduling a session, for instance they may set aside an afternoon when they can input a range of data collected during the previous week or so. They then log into the database as a 'remote user'.

A major issue appears to be that only one remote user can be logged in at any one time. Any attempts to enter the database while another remote user is logged on will cause the system to freeze and any data inputted during that session may be lost.

The community centre, from which the Oxford project operates, has limited IT and the coordinator sought to link with the database using a dongle, a small USB device. This provided only limited and unreliable access to the database so this practice was discontinued and internet connection sought via a home computer.

5.2.5 Uptake

The service uptake rate in the current project ranged from 76- 85%, however all PSP sites experience families who do not take up the offer of the service; one coordinator described the difficulty of this situation:

Some of them won't even engage with me. So I'll try and get them on the phone, never answer the phone. And in that... we then log it as a referral, but we say they didn't engage. Um. We send them a letter with my number on saying you can contact me and then we copy that to the referrer. Yeah so they might refer. Then we say that they're not engaged.

6. Discussion

The Need for the PSP

The findings of this research suggest that the PSP is filling a significant gap in existing provision for women experiencing perinatal mental health problems (e.g. anxiety and depression). A wide range of practitioners referred women to the PSP including social workers, midwives, health visitors and a perinatal mental health service seeking input for women discharged from the service but still in need of further, less intensive support. The flow of referrals to the PSP increased over time, with the result that many projects were soon working to full capacity and waiting lists had to be introduced. The PSP was perceived across all sites as providing a service that complemented existing services, and many health professionals such as midwives and health visitors referred to high levels of unmet need in their areas.

Benefits of the PSP

The results of the quantitative data from around one-third of participating women indicated significant improvements in anxiety and depression, self-esteem, and warm feelings toward the baby. These results were reflected in the users' reports of the service, which were unreservedly unanimous in praise of the PSP, and which was described by some as being life changing. The holistic and flexible nature of the support on offer was highly valued, and women appreciated the range of additional support available, such as for example, attendance at mother-baby groups. The data suggests that following involvement with the PSP, service users were able to access a variety of services, and that this involved opportunities for socialising with other mothers and infants (parent support) in addition to opportunities for learning ways of promoting their infants wellbeing (parenting support).

Volunteer befrienders were keen to be involved in the PSP and found the training to be both useful and interesting. They described feeling well supported in their role and as finding it highly rewarding. The positive impact of befriending was evident in their accounts not only for themselves but also for their families.

7. Recommendations for Practice

1. Antenatal Working

The PSP was intended to support women during the perinatal period (although policy regarding referrals during the ante-natal period was inconsistent across sites with one site only taking referrals from 38 weeks antenatally), but most referrals were of women experiencing postnatal problems. Research shows that antenatal anxiety and depression are common, and have a significant deleterious impact on the infant (see background for further detail), and there would as such appear to be further scope for the PSP to engage in more preventive work by offering support to more women during this period. This would require the PSP to target midwives as a potential source of referral of women with antenatal anxiety or depression alongside health visitors who are now conducting the Ante-Natal Promotional Interview at 28 weeks of pregnancy as part of the Healthy Child Programme. Intervention during this period would enable the PSP to offer opportunities for more sustained support (i.e. over a longer period) that would not only be aimed at addressing the women's mental state, but could also focus on promoting the relationship with the baby (see below for further information).

2. Processes of working

There were clear advantages to projects being set up in established Family Action sites, in terms of them being better supported and connected (i.e. having access to personnel, basic systems and processes that aided smooth implementation and running of the PSP). The choice of site for the PSP also appeared to have a bearing on how the project was established and the standards to which it operated. Being based in locations that gave access to other services and professionals appeared to offer a range of benefits to project co-ordinators, volunteers and families alike.

The Project Coordinator is key to the success of the PSP, and this intensive and challenging role could be better supported by the addition of a few key resources, including administrative support. Good line management and support are vital in this role and the presence of a steering group appeared to have a positive impact. The role of the National Coordinator might also include the provision of strategic help to shape and support the individual PSPs, in order to promote consistency. The post

holder should also have access to the database so that enquires regarding project information can be fielded at national as well as a local level.

3. PSP training

During the time of this evaluation the training manual for the PSP was still being developed, and the training across the four sites was as such variable, and largely dependent on the skills and knowledge of the local site co-ordinators. The finalisation of the PSP training manual will remedy this lack of standardisation.

The results of this study suggest that the existing training would be strengthened by a greater focus on volunteer methods of promoting bonding and attachment both during the ante- and post-natal periods, and that this outcome should be one of the categories to be completed in the observation/monitoring form. Volunteer befrienders might also benefit from the inclusion of practical guides to translating such goals into practice, such as, for example, 'speaking for the baby' and the 'Understanding your baby' resource (Ranger & Mincke 2010).

4. Data collection and monitoring

All Coordinators have experienced difficulties in obtaining end of project data, with many participants disengaging from the project as their mental health and wellbeing improves. Six month post project data was scant across all sites, but particularly those where there were significant numbers of users living in temporary accommodation. Mechanisms for improving data collection could include the use of technology to administer the questionnaires (e.g. email questionnaires and telephone rather than face-to-face contact). Data collection could also be improved by questionnaires being set out in a more user-friendly format (i.e. printed on coloured paper and presented as a booklet with titles such as 'Hospital Anxiety and Depression Scale' removed).

Conclusion

The PSP was highly rated by all stakeholders, and appears to be filling a significant gap in service provision with women who have a high level of unmet need. There would appear to be further scope for the PSP to work with service users in the

antenatal period where the impact may be even greater. This would involve shifting the emphasis in terms of referring agencies (e.g. encouraging more referrals during pregnancy from midwives). There would also appear to scope for further standardisation across the sites and for changes to the methods of data collection.

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Appendix

Family-Action Perinatal Project.

Guidelines for referral.



The aims of the service:

- To help women who are or who may be at risk of experiencing Perinatal Depression - who are pregnant or with a child who is under one years old.
- To provide one to one support in the home around the issues of social isolation, mental or emotional well being.
- To provide group parenting sessions/drop-ins.
- To recruit and train suitable volunteers/befrienders to carry out these services.

Criteria which can lead to a successful referral:

- The woman referred has a sense of self agency with regard to goal setting and planning.
- Has had an unplanned pregnancy.
- Has given birth to a child with a low birth weight.
- Has given birth through caesarean delivery.
- Has been diagnosed with Perinatal Depression.
- Is socially isolated presenting with low mood or becoming increasingly isolated or withdrawn.
- Is experiencing impaired functioning due directly to emotional wellbeing difficulties or mental health difficulties which do not require crisis intervention (unless part of multi-team action plan).
- Presenting with anxieties, depression or emotional distress that impairs their normal daily functioning, and/or causes others to be concerned for the their welfare or the welfare of their child/other children.
- Experiencing mild/moderate mood changes.
- Experiencing mild/moderate fears and using avoidance behaviours.
- Displaying adverse reactions to the impending birth or a current new born.

Appendix (i): Guidelines for Referral

- Needs assistance with parenting skills: emotional or practical in coping with new born or child under one years old.

Referrers: Should the woman you are wishing to refer fall into any of the categories below please ensure that you liaise with the co-ordinator of the Perinatal project in your area to discuss risk, priority and suitability.

Is presenting with drug or alcohol misuse or lives with another who misuses.

Is actively responding to voices so much so that they lose a sense of themselves or the environment. Showing other signs of psychosis, or relapse.

Has a history of severe/ enduring eating disorders.

Has a history or is presenting with persistent/serious/enduring self-harm so is deemed suitable for MDT involvement.

Is currently subject to Domestic Violence.

Is currently the subject of proceedings in the Family or High Court, and permission by the court to proceed has not been granted/ or is subject to pending court involvement.

Is currently subject to, or is deemed to require an imminent child protection investigation under section 47 of the Children's Act 1989, and this has not been completed. Or is subject to a Child Protection plan or Child in Need plan.

Is currently involved in legal issues/or requiring reports / or written psychological assessments.

Is subject to a legal action wherein evidence has not yet been collected.

In significant distress following a recent death that has occurred within traumatic events.

Is experiencing possible post trauma responses (intrusive flashbacks, unprovoked anger).

Presenting with recent (within a few weeks/days) overdose or suicide attempt/s.

Presents with low mood or depression due to current housing issues.

Theory of change workshop

1 Introduction

One of the aims of the research was to explore with Family Action their 'Theory of change' and a workshop was facilitated by Professor Jane Barlow, with participants from Family Action head office, and PSP staff. A range of personnel were among the 14 people present at the workshop including Organisation Development Manager, Head of Policy and Campaigns, Fundraising officer, IT officer, the National Perinatal Project Co-ordinator, the four Project Coordinators and one Volunteer Befriender.

The workshop was held on Wednesday November 2nd 2011 and ran from 11am - 1.30 pm. The expressed aim of the day was for Family Action to consider, agree and articulate the Perinatal Support Project's 'theory of change'.

2. Aims

A 'theory of change' was described by the facilitators as follows:

'a way to describe the set of assumptions that explain both the long term goal/outcome and also the connections between program activities and outcomes that occur at each step of the way'

It was noted that the project cannot be effective if project providers are not clear about how they plan to achieve their goals, and that a theory of change should underpin the training provided. The focus of the session involved the following activities:

1. Identification of the key outcomes of the PSP and the ways in which these are being measured;
2. Identifying the underlying causes of the problem areas in which change was being sought;
3. Identifying the aspects of the intervention that are aimed at facilitating change in these outcomes;

Appendix (ii) Theory of change workshop

4. Examination of the training that is provided to VB to enable them to deliver the intervention in a way that is consistent with the theory of change.

3. Session Outcomes

3.1 Identification of Key Outcomes

The key outcomes were agreed to be the following:

1. Improve attachment of mother and baby;
2. Reduce social isolation;
3. Improve the mental health of the mother;
4. Improve volunteer and client self-esteem.

Further discussion produced a further four outcomes:

To improve outcomes for the child

To improve child development

To improve the economic wellbeing of the family

Provide access to other services such as health care and benefits

The group felt it was important to note that PSP provides a significant service, filling the gap left by statutory services, and working with individuals in a flexible and multi-faceted way.

4. Measures

Measurement and assessment of progress on the four main outcomes are undertaken using the following outcome measures:

- Mental health and wellbeing: Hospital anxiety depression scale (HADS).
- Mother-child relationship: Mother Object Relationship scale (MORS).
- Social isolation: Maternal Social Support Index (MSSI).
- Rosenberg Self-Esteem Inventory (RSI)

Appendix (ii) Theory of change workshop

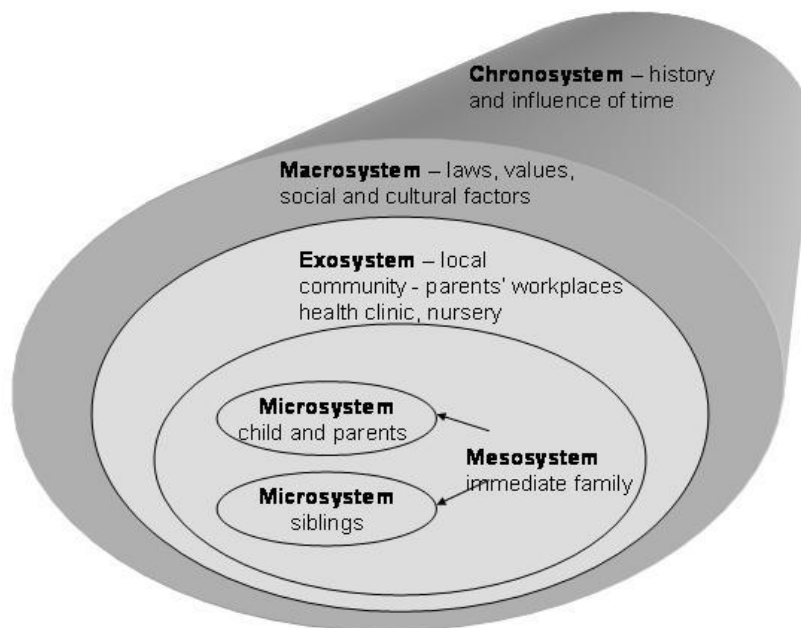
It was noted that no measurements or assessments were made of one of the key outcomes (i.e. attachment), but that the MORS provides a proxy measure of this outcome.

5. Underlying causes of the problems

The group were then asked to think about the underlying mechanisms for the two key outcomes - maternal depression; infant attachment security.

The group were encouraged to think about a range of levels of contributory factors using Bronfenbrenner's theory of ecological development (1979). The following model is adapted by Underdown (2007).

Bronfenbrenner's theory of ecological development



For example, with regard to attachment, working groups of two or three attendees identified the following factors as contributing to infant attachment security: **Proximal factors** included attunement, maternal communication to baby: smiles, sings, baby talk, cuddle, plays face time; baby massage etc. **Distal factors** included: Mother's needs, support, physical security and birth experience; anxiety and depression; support from friends and peer group; self-esteem etc.

Appendix (ii) Theory of change workshop

5.1 How PSP facilitates change in these Outcomes

The group then moved on to think about the unique contribution of the PSP to facilitating change in the two key outcomes, and to note the current training in place to support this activity.

Contribution of the PSP	Training
Modelling	Role Plays
Baby: communication Exploration Noticing and recognition	Infant cues and states
Positive Parenting: Strengthening families Incredible years Solihull Approach PEEP	Some Project Coordinators had accessed training prior to their current post, from the programmes listed

6. Training to facilitate change in the identified outcomes

The final session focused on exploring the current training offered by the PSP to volunteer befrienders. The following issues were identified:

- The training is currently organised and developed on a local basis, and the four Project Coordinators plan and deliver the training programmes on an independent basis with the result that the training across the PSP's may vary;
- Currently there are no standard elements across the four PSP's although plans to produce a core training manual are underway, with the national project coordinator devising a PSP training manual which will pull elements of best practice from each area together, and should be ready in draft form by December. All projects will offer six days of training, over a period of six weeks.